UTILIZATION MANAGEMENT

1. Utilization Management (UM) Program

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medical care services. Contractor is responsible to ensure that the UM program includes:

A. Qualified staff responsible for the UM program.

B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.

C. Contractor shall ensure that the UM program allows for second opinions by specialists to any Member upon request.

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

E. Contractor shall communicate to health care practitioners the procedures and services that require prior authorization and ensure that all health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.

   Contractor shall ensure that all health care practitioners are aware of the referral processes and tracking procedures.

G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

These activities shall be done in accordance with Health and Safety Code Section 1363.5 and Title 28, CCR, Section 1300.70(b)(2)(H) & (c).

2. Pre-Authorizations and Review Procedures

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

A. Qualified medical professionals supervise review decisions and a qualified Physician will review all denials.

B. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

C. Reasons for decisions are clearly documented.

D. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13, Member Services. There shall be a well-publicized appeals procedure for both providers and patients.

E. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

F. Prior Authorization requirements shall not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

3. Timeframes for Medical Authorization

A. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

B. Post-stabilization: Response to request within 30 minutes or the service is deemed approved in accordance with Title 22- Section 53855 (a), or any future amendments thereto.

C. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.

D. Concurrent Review of authorization or treatment regimen already in place: 72 hours or consistent with urgency of the member's medical condition in accordance with Health & Safety Code Section 1367.215, or any future amendments thereto.

E. Retrospective review: Within 30 days in accordance with Health & Safety Code Section 1367.215, or any future amendments thereto.

F. Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with Welfare & Institutions Code, Section 14185 or any future amendments thereto.

G. Routine authorizations: Five (5) business days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health & Safety Code, Section 1367.215, or any future amendments thereto.

H. Hospice care: 24 hour response.

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHS upon request.

5. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, provision 6, Delegation of Quality Improvement Activities.